

SECTION

7

Ambulatory care

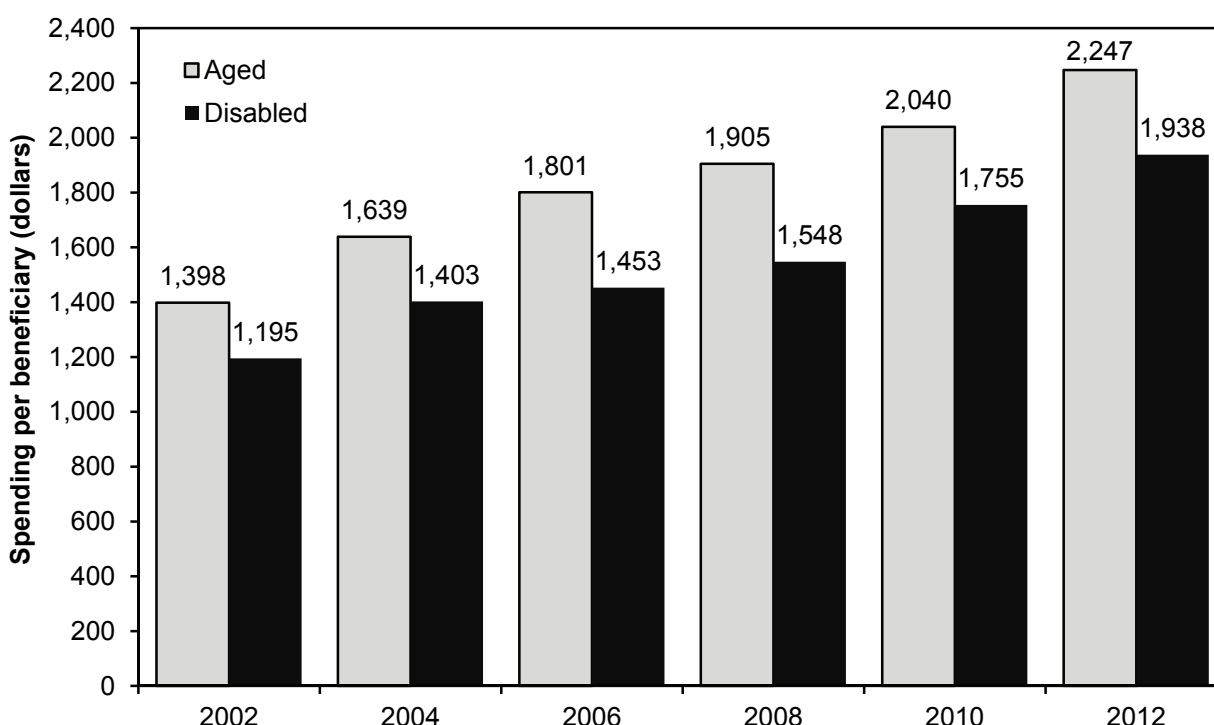
**Physicians and other
health professionals**

Hospital outpatient services

Ambulatory surgical centers

Imaging services

Chart 7-1. Medicare spending per FFS beneficiary on physician fee-schedule services, 2002–2012

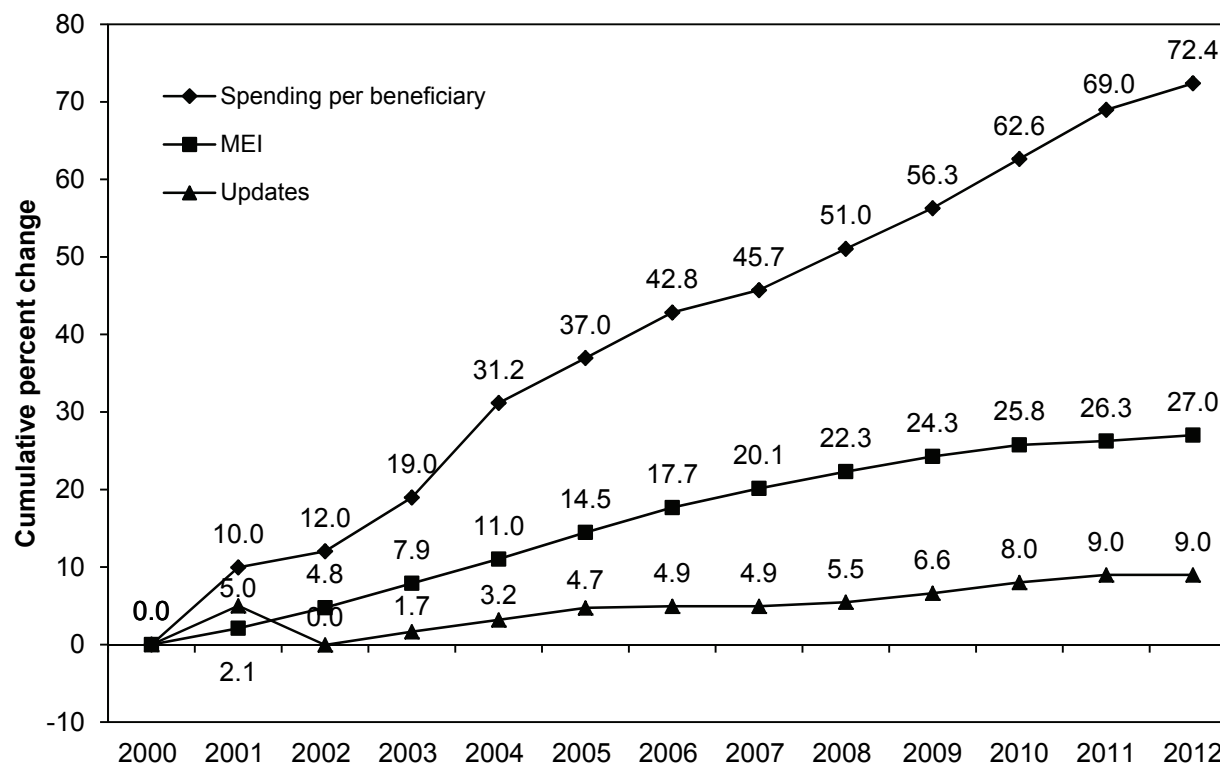


Note: FFS (fee-for-service). Dollar amounts are Medicare spending only and do not include beneficiary coinsurance. The category “disabled” excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries age 65 or over are included in the aged category.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

- Physicians and other health professionals perform a broad range of services in the Medicare physician fee schedule, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In addition to physicians, these services may be provided by other health professionals (e.g., nurse practitioners, chiropractors, and physical therapists).
- FFS spending per beneficiary for physician fee-schedule services has increased annually. From 2002 to 2012, Medicare spending per FFS beneficiary on these services grew 60 percent.
- Growth in spending on physician fee-schedule services is one of several contributions to Part B premium increases over this time period.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries. In 2012, for example, per capita spending for disabled beneficiaries was \$1,938, compared with \$2,247 for aged beneficiaries.

Chart 7-2. Volume growth has raised physician spending more than input prices and payment updates, 2000–2012

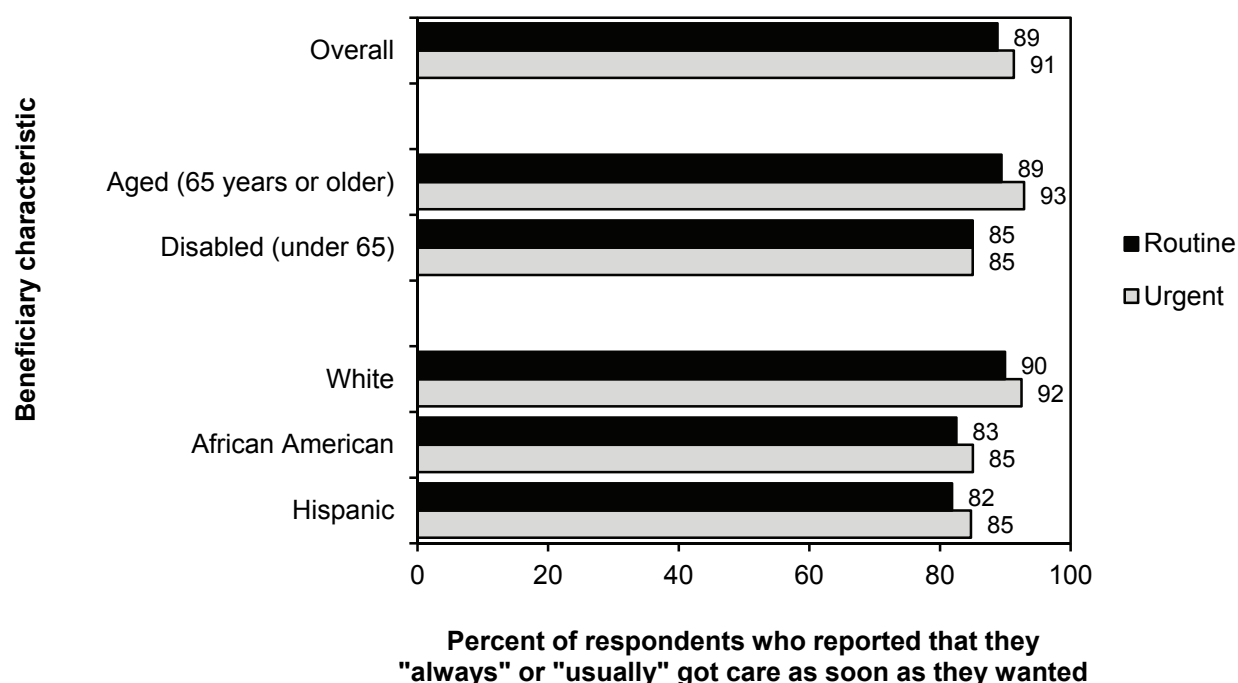


Note: MEI (Medicare Economic Index).

Source: AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.

- From 2000 to 2012, Medicare spending per beneficiary for physician services increased by 72 percent.
- This spending grew much more rapidly over the period than both the payment rate updates and the MEI. Physician fee-schedule payment updates totaled 9 percent, and the MEI increased 27 percent.
- Growth in the volume of services contributed much more to the rapid increase in Medicare spending than payment rate updates. Both factors—updates and volume growth—combined to increase physician revenues.

Chart 7-3. Most beneficiaries report that they can always or usually get timely care, 2012



Note: In the survey, "routine care" refers to appointments in doctors' offices or clinics that are not for care needed "right away." "Urgent care" refers to care needed right away for an illness, injury, or condition. Nonapplicable respondents (e.g., those who did not seek routine or urgent care in the past six months) were excluded.

Source: MedPAC analysis of Consumer Assessment of Healthcare Providers and Systems® for fee-for-service, Medicare 2012 (unweighted).

- Overall, in 2012, 89 percent of Medicare beneficiaries who reported making an appointment for routine care at a doctor's office or clinic said that they always or usually got care as soon as they wanted. For beneficiaries who reported needing urgent care in a clinic, emergency room, or doctor's office, 91 percent reported that they always or usually got care as soon as they wanted.
- Compared with beneficiaries age 65 or older, those under age 65 and eligible for Medicare on the basis of disability were less likely to report that they always or usually got routine or urgent care as soon as they wanted.
- Smaller percentages of African American and Hispanic beneficiaries reported that they always or usually got care as soon as they wanted, compared with White beneficiaries.

Chart 7-4. Medicare beneficiaries report better ability to get timely appointments with physicians, compared with privately insured individuals, 2010–2013

Survey question	Medicare (age 65 or older)				Private insurance (age 50–64)			
	2010	2011	2012	2013	2010	2011	2012	2013
Unwanted delay in getting an appointment: Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”								
For routine care								
Never	75% ^{ab}	74% ^a	77% ^{ab}	73% ^a	72% ^{ab}	71% ^a	72% ^{ab}	69% ^a
Sometimes	17 ^{ab}	18 ^a	17 ^{ab}	20 ^a	21 ^{ab}	21 ^a	21 ^{ab}	23 ^a
Usually	3 ^a	3	3	3 ^a	4 ^a	4	3 ^b	4 ^a
Always	2	2 ^a	2 ^{ab}	3	3	3 ^a	3 ^a	3
For illness or injury								
Never	83 ^a	82	84 ^a	82 ^a	80 ^{ab}	79	80 ^a	77 ^a
Sometimes	13 ^a	14 ^a	12 ^a	14 ^a	15 ^a	17 ^a	16 ^{ab}	17 ^a
Usually	2	2	2	2 ^a	2	2	2	3 ^a
Always	1 ^a	1	1 ^a	1	2 ^a	1	2 ^a	2

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in years 2010–2013. Sample sizes for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.

^b Statistically significant difference (at a 95 percent confidence level) from 2013 within the same insurance coverage category.

Source: MedPAC-sponsored telephone surveys conducted in 2010, 2011, 2012, and 2013.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Their ability to schedule timely appointments is one indicator of access we examine.
- Medicare beneficiaries report better access to physicians for appointments than privately insured individuals age 50 to 64. For example, in 2013, 73 percent of Medicare beneficiaries and 69 percent of privately insured individuals reported “never” having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries also report more timely appointments for injury and illness than their privately insured counterparts.
- Appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-5. Medicare and privately insured patients who are looking for a new physician report more difficulty finding one in primary care, 2010–2013

Survey question	Medicare (age 65 or older)				Private insurance (age 50–64)			
	2010	2011	2012	2013	2010	2011	2012	2013
Looking for a new physician: “In the past 12 months, have you tried to get a new ...?” (Percent answering “Yes”)								
Primary care physician	7	6 ^b	7	7	7	7	7	8
Specialist	13 ^{ab}	14 ^a	13 ^a	14	15 ^a	16 ^a	18 ^a	16
Getting a new physician: Among those who tried to get an appointment with a new physician, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it ...”								
Primary care physician								
No problem	79 ^a	65	72	70	69 ^a	68	75	67
Small problem	8	12	14	11	12	16	9	15
Big problem	12	23 ^a	14	17	19	14 ^a	15	18
Specialist								
No problem	87 ^a	84	87	86	82 ^{ab}	86	86	87
Small problem	6 ^a	8	6	8	11 ^{ab}	8	7	6
Big problem	5	7	7	5	6	6	7	7

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in 2010–2013. Sample sizes for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.

^b Statistically significant difference (at a 95 percent confidence level) from 2013 within the same insurance coverage category.

Source: MedPAC-sponsored telephone surveys, conducted in 2010, 2011, 2012 and 2013.

- In 2013, only 7 percent of Medicare beneficiaries and 8 percent of privately insured individuals reported looking for a new primary care physician. This finding suggests that most people were either satisfied with their current physician or did not need to look for one.
- Of the 7 percent of Medicare beneficiaries who looked for a new primary care physician in 2013, 28 percent reported problems finding one—17 percent reported their problem as “big,” and 11 percent reported their problem as “small.” Although this number indicates that only about 2 percent of the total Medicare population reported problems finding a primary care physician, the Commission is concerned about the continuing trend of greater access problems for primary care.

Of the 8 percent of privately insured individuals who looked for a new primary care physician in 2013, 33 percent reported problems finding one—18 percent reported their problem as “big,” and 15 percent reported their problem as “small.”

- For 2013, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician than a new specialist.

Chart 7-6. Access to physician care is better for Medicare beneficiaries than privately insured individuals, but minorities in both groups report problems slightly more frequently, 2013

Survey question	Medicare (age 65 or older)			Private insurance (age 50–64)		
	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”						
For routine care						
Never	73% ^a	74% ^a	71% ^a	69% ^a	70% ^{ab}	65% ^{ab}
Sometimes	20 ^a	20 ^a	19 ^a	23 ^a	23 ^a	25 ^a
Usually	3 ^a	3 ^a	4	4 ^a	5 ^a	4
Always	3	2 ^b	4 ^b	3	3 ^b	5 ^b
For illness or injury						
Never	82 ^a	83 ^{ab}	77 ^b	77 ^a	77 ^a	76
Sometimes	14 ^a	13 ^a	16	17 ^a	18 ^a	17
Usually	2 ^a	2 ^{ab}	3 ^b	3 ^a	3 ^a	2
Always	1	1 ^b	3 ^b	2	1	2

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2013. Sample size for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.

^b Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2013.

- In 2013, Medicare beneficiaries reported better access to physicians for appointments than privately insured individuals age 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2013, 83 percent of White Medicare beneficiaries reported “never” having to wait longer than they wanted to get an appointment for an illness or injury, compared with 77 percent of minority beneficiaries.
- Although minorities experienced slightly more access problems, minorities with Medicare were less likely to experience problems than minorities with private insurance.

Chart 7-7. Differences in access to new physicians are most apparent among minority Medicare and privately insured patients who are looking for a new specialist, 2013

Survey question	Medicare (age 65 or older)			Private insurance (age 50–64)		
	All	White	Minority	All	White	Minority
Looking for a new physician: “In the past 12 months, have you tried to get a new ...?”						
Primary care physician	7%	7%	7%	8%	8%	7%
Specialist	14	15 ^b	12 ^b	16	17 ^b	12 ^b
Getting a new physician: Among those who tried to get an appointment with a new physician, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it ...”						
Primary care physician						
No problem	70	72	65	67	67	66
Small problem	11	9 ^a	19 ^a	15	15	16
Big problem	17	18	14	18	19	16
Specialist						
No problem	86	87	80	87	88	86
Small problem	8	7	12 ^a	6	6	4 ^a
Big problem	5	5	7	7	6	9

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2013. Sample size for individual questions varied.

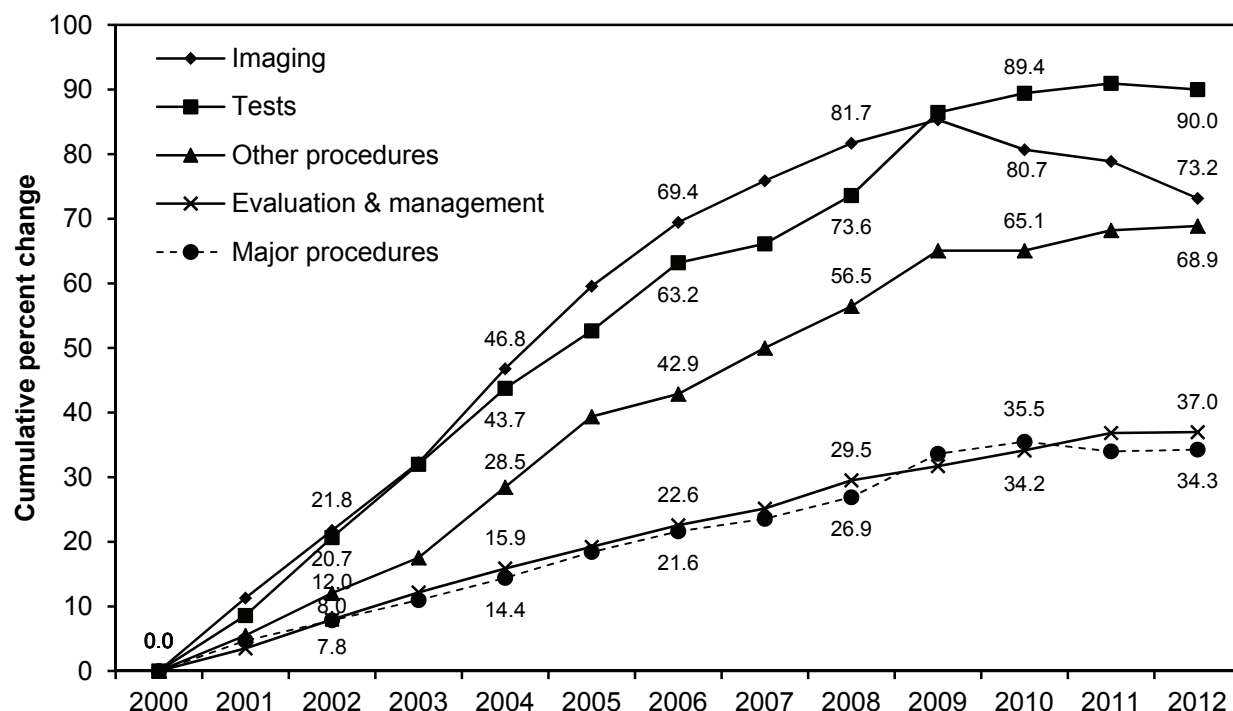
^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.

^b Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys conducted in 2013.

- Among the small percentage of Medicare beneficiaries and privately insured individuals looking for a new specialist, minorities were more likely than Whites to report problems finding one. For example, in 2013, 87 percent of White Medicare beneficiaries reported “no problem” finding a new specialist, compared with 80 percent of minority beneficiaries.
- Although minorities experienced more access problems, minorities with Medicare were generally less likely to experience problems than minorities with private insurance.

Chart 7-8. Growth in volume per beneficiary of physician and other qualified health professional services, 2000–2012

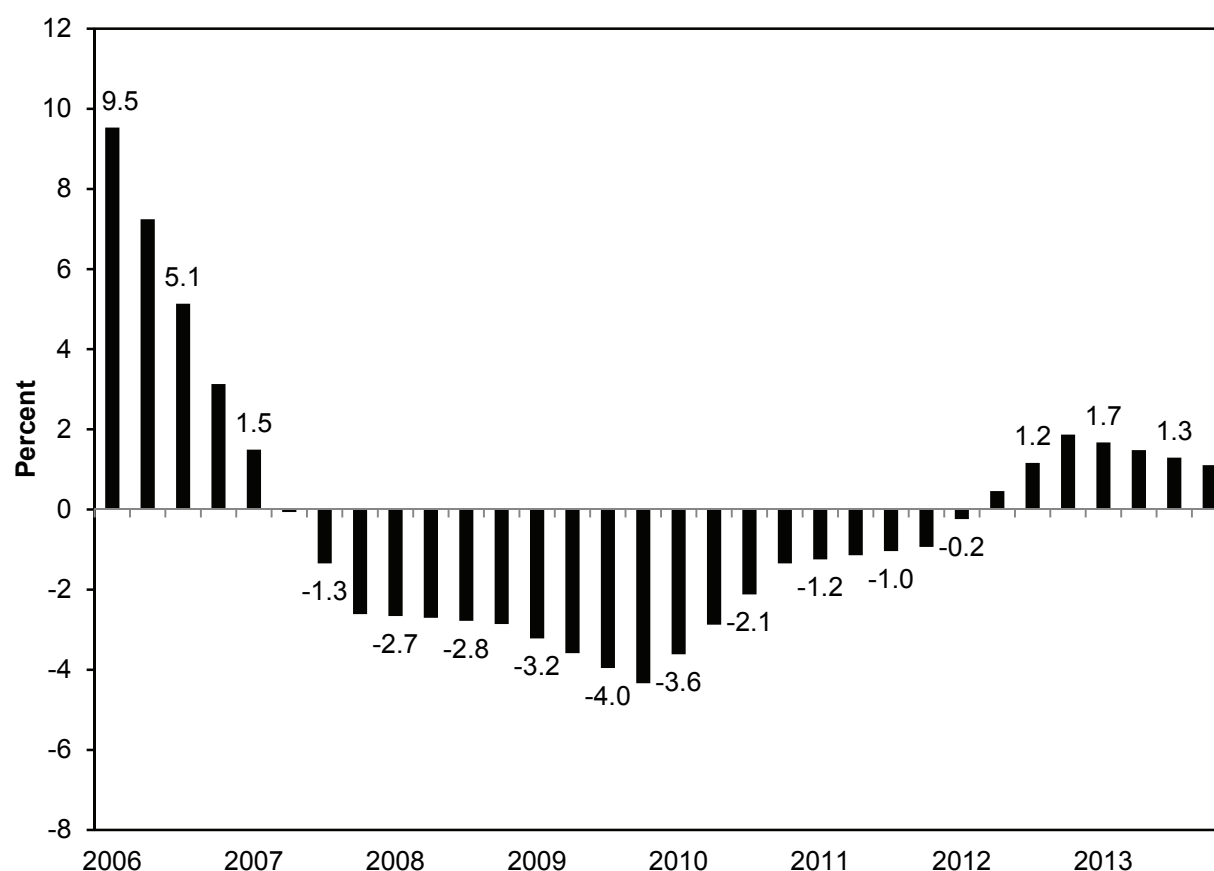


Note: "Volume" is units of service multiplied by relative value units from the fee schedule for services furnished by physicians and other qualified health professionals. Volume for all years is measured on a common scale, with relative value units for 2012. Volume growth for evaluation and management (E&M) from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2011, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- From 2000 to 2012, the volume of some services furnished by physicians and other qualified health professionals grew much more than others.
- The volume of tests grew by 90 percent, the volume of imaging grew by 73 percent, and the volume of "other procedures" (procedures other than major procedures) grew by 69 percent. The comparable growth rates for major procedures and E&M services were only 37 percent and 34 percent, respectively.
- Volume growth increases Medicare spending, limiting funds available for other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Overall volume increases translate directly to growth in both Part B spending and premiums. They are also largely responsible for the negative updates required by the sustainable growth rate formula. Rapid volume growth may be a sign that some services in the physician fee schedule are mispriced.

Chart 7-9. Changes in physicians' professional liability insurance premiums, 2006–2013

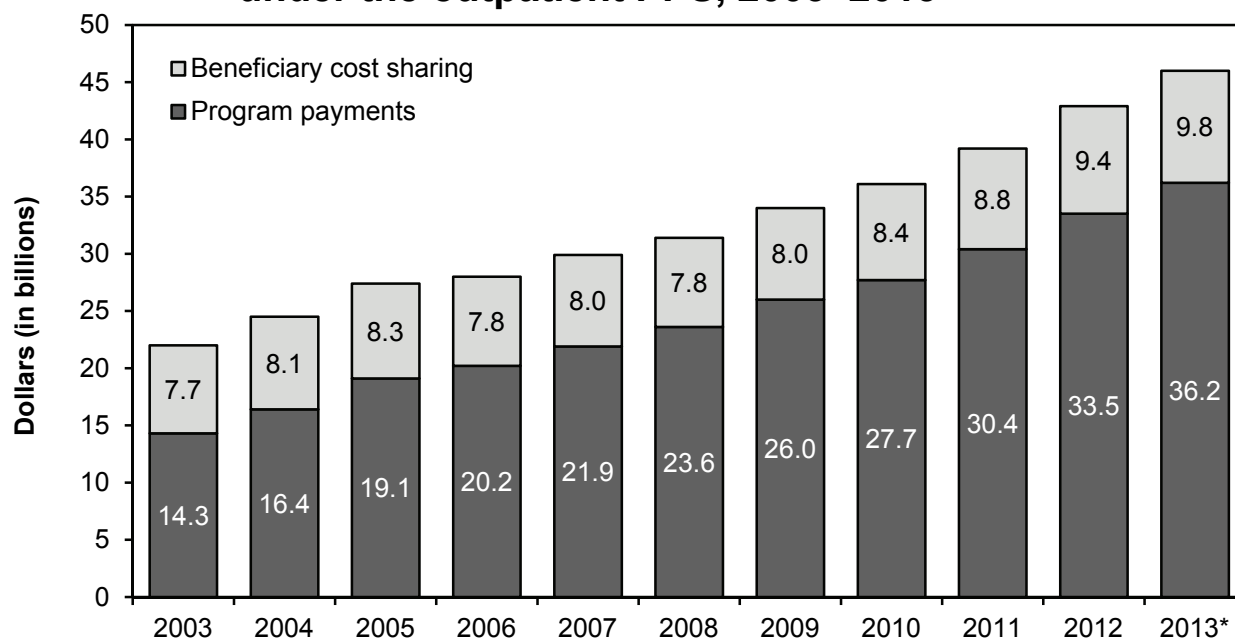


Note: Bars represent a four-quarter moving average percent change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the physician fee schedule. PLI premiums generally follow a cyclical pattern, alternating between periods of low premiums—characterized by high investment returns for insurers and vigorous competition—and high premiums—characterized by declining investment returns and market exit.
- After rapid increases in PLI premiums between 2002 and 2004 (data not shown), premium growth slowed in 2005 and 2006, becoming negative in 2007 and remaining negative through the first quarter of 2012. Premiums began to rise slowly in the second quarter of 2012.

Chart 7-10. Spending on hospital outpatient services covered under the outpatient PPS, 2003–2013



Note: PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services.
*Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS from calendar year 2003 to 2013 increased by 110 percent, reaching \$46.0 billion. The Office of the Actuary projects continued growth in total spending, averaging 11.1 percent per year from 2013 to 2015.
- In 2001, the first full year of the outpatient PPS, spending under the PPS was \$20.1 billion, including \$12.1 billion by the program and \$8.0 billion in beneficiary cost sharing. Spending under the outpatient PPS is expected to rise to \$46.0 billion in 2013 (\$36.2 billion program spending; \$9.8 billion beneficiary copayments). The outpatient PPS accounted for about 6 percent of total Medicare spending by the program in 2013.
- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 22 percent in 2012. Chart 7-14 provides more detail on coinsurance.

Chart 7-11. Most hospitals provide outpatient services

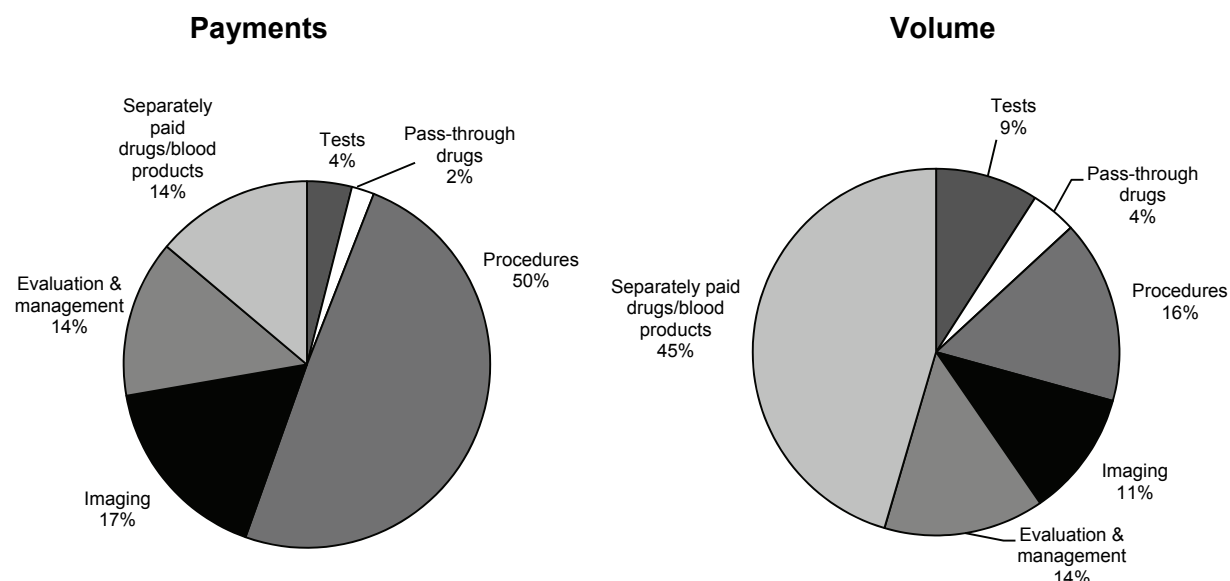
Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2002	4,210	94%	84%	N/A
2004	3,882	94	86	N/A
2006	3,651	94	86	N/A
2008	3,607	94	87	N/A
2010	3,518	95	90	N/A
2012	3,483	95	91	93%
2013	3,456	96	92	93

Note: N/A (not applicable). We list emergency services from 2002 through 2010 as N/A because the data source we used in this chart changed the variable for identifying hospitals' provision of emergency services. We believe this change in variable definition makes it appear that the percentage of hospitals providing emergency services increased sharply from 2010 to 2012, but we question whether such a large increase actually occurred. This chart includes services provided or arranged by short-term hospitals and excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system (PPS) sharply declined from 2002 through 2006, largely because of growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. Since 2006, the decline in the number of outpatient PPS hospitals has slowed.
- The percent of hospitals providing outpatient services remained stable, and the percent offering outpatient surgery steadily increased from 2002 through 2013. We also believe the percent offering emergency services has remained fairly stable, but we are not certain. In 2011, CMS changed the variable in the Provider of Services file we use to calculate the share of hospitals offering emergency services, so the 2012 and 2013 numbers are not precisely comparable with prior years.

Chart 7-12. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2012



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing but do not include hold-harmless payments to rural hospitals. Services are grouped into evaluation and management, procedures, imaging, and tests, according to the Berenson–Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. The percentage of volume attributable to separately paid drugs and blood products increased substantially over 2011 largely because of the payment status of very low-cost drugs changing from “packaged” in 2011 to “paid separately” in 2012. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the 5 percent standard analytic file of outpatient claims for 2012.

- Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently than volume. For example, in 2012, procedures accounted for 50 percent of payments but only 16 percent of volume.
- Procedures (e.g., endoscopies, surgeries, and skin and musculoskeletal procedures) account for the greatest share of payments for services (50 percent) in 2012, followed by imaging services (17 percent), separately paid drugs and blood products (14 percent), and evaluation and management services (14 percent).

Chart 7-13. Hospital outpatient services with the highest Medicare expenditures, 2012

APC title	Share of payments	Volume (thousands)	Payment rate
Total	44%		
All emergency visits	6	12,665	\$188
All clinic visits	5	24,209	76
Diagnostic cardiac catheterization	3	480	2,720
Cataract procedures with IOL insert	2	519	1,672
Level II extended assessment & management composite	2	1,815	721
Insertion of cardioverter–defibrillator pulse generator	2	31	23,915
Level I plain film except teeth	2	16,136	45
Insertion/replacement/repair of cardioverter–defibrillator leads	2	23	29,835
Lower gastrointestinal endoscopy	2	1,101	656
Coronary angioplasty, valvuloplasty, and level I endovascular revascularization of the lower extremity	2	158	4,611
Transcatheter placement of intracoronary drug-eluting stents	1	89	7,398
Combined abdomen and pelvis CT with contrast*	1	1,052	581
Level II endovascular revascularization of the lower extremity**	1	82	8,087
IMRT treatment delivery	1	1,300	458
Level II echocardiogram without contrast	1	1,556	393
Level II cardiac imaging	1	836	672
Level II drug administration*	1	15,911	35
Computed tomography without contrast	1	2,715	192
Level II laparoscopy	1	143	3,357
CT and CTA with contrast composite	1	648	722
Level III nerve injections	1	856	522
Level III cystourethroscopy and other genitourinary procedures	1	272	1,841
MRI and magnetic resonance angiography without contrast material	1	1,185	339
Insertion/replacement/conversion of permanent dual chamber pacemaker or pacing electrode	1	42	9,638
Level I upper gastrointestinal procedures	1	791	592
Average APC		459	128

Note: APC (ambulatory payment classification), IOL (intraocular lens), CT (computed tomography), IMRT (intensity-modulated radiation therapy), CTA (computed tomography angiography), MRI (magnetic resonance imaging). The payment rate for “All emergency visits” is a weighted average of payment rates from 10 APCs, and the payment rate for “All clinic visits” is a weighted average of payment rates from 5 APCs.

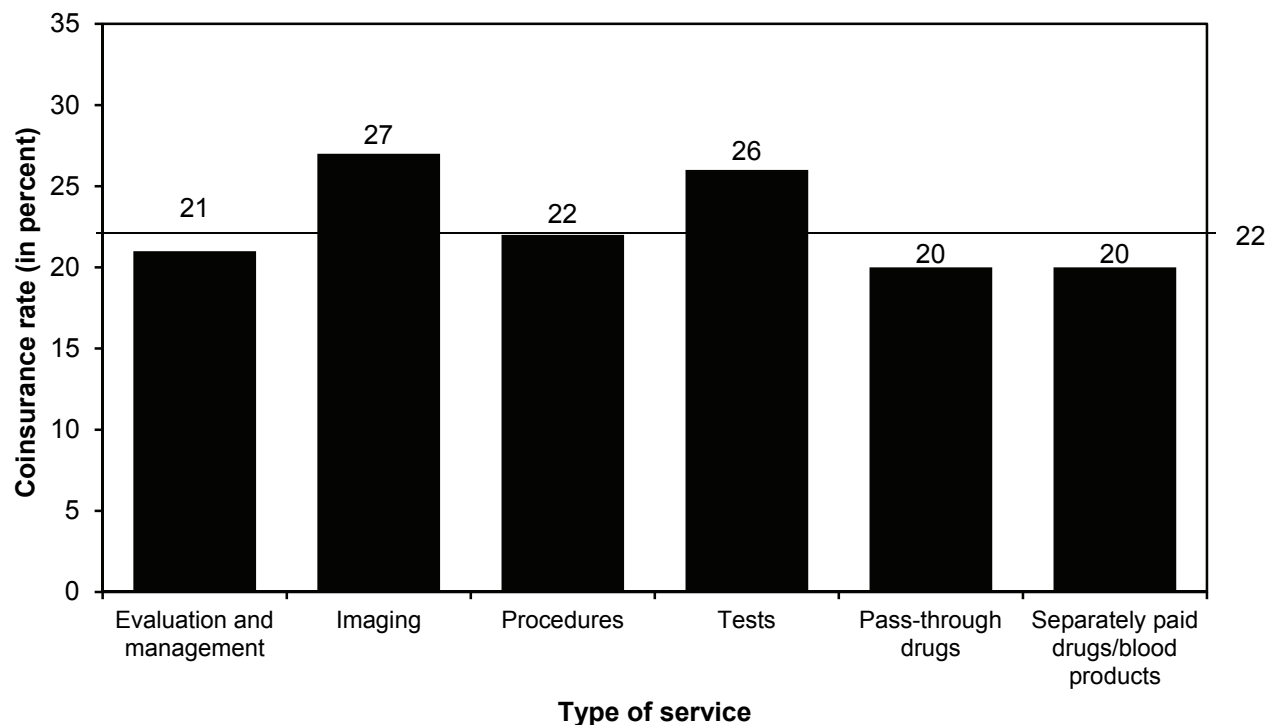
*Did not appear on the list for 2011.

**APC has been renamed since 2011.

Source: MedPAC analysis of 5 percent analytic files of outpatient claims for calendar year 2012.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 7-14. Medicare coinsurance rates, by type of hospital outpatient service, 2012



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of the 5 percent standard analytic files of outpatient claims for 2012.

- Before CMS began using the outpatient prospective payment system (PPS), beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented an increasingly large share of total payments over time.
- In adopting the outpatient PPS, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments has declined over time.
- The coinsurance rate differs for each service. Some services, such as imaging, have relatively high rates of coinsurance—27 percent in 2012. Other services, such as evaluation and management services, have coinsurance rates of 21 percent.
- In 2012, the average coinsurance rate was about 22 percent.

Chart 7-15. Effects of hold-harmless and SCH transfer payments on hospitals' outpatient revenue, 2010–2012

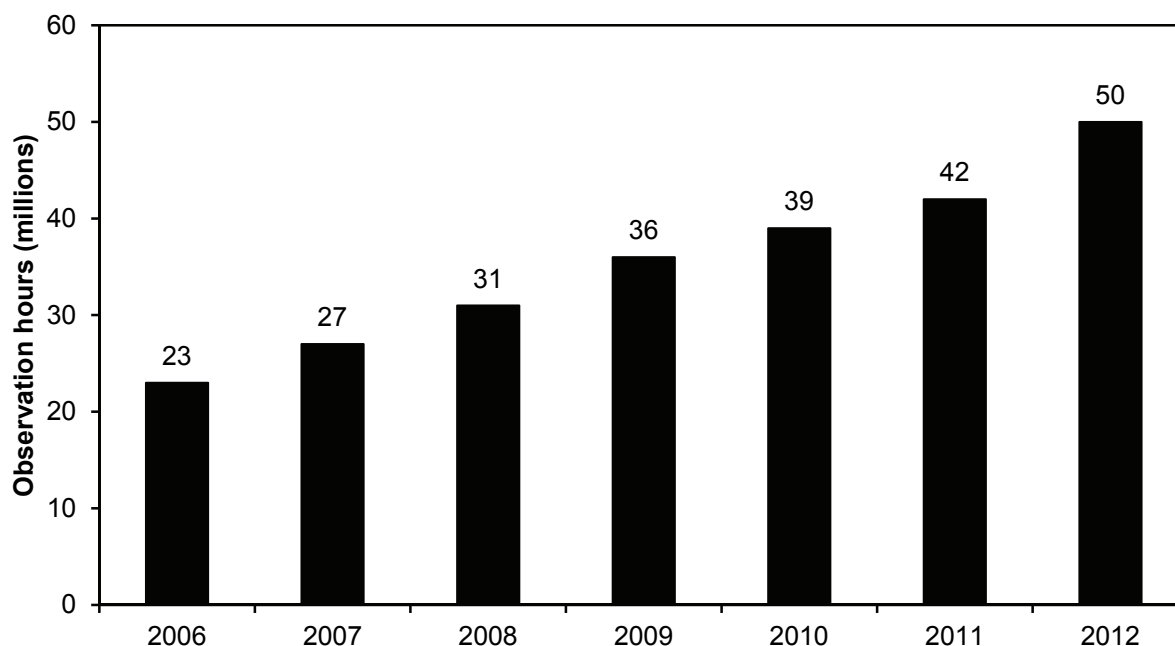
Hospital group	2010		2011		2012	
	Number of hospitals	Share of payments from hold harmless and SCH transfer	Number of hospitals	Share of payments from hold harmless and SCH transfer	Number of hospitals	Share of payments from hold harmless and SCH transfer
All hospitals	3,127	0.4%	3,070	0.4%	2,998	0.4%
Urban	2,231	–0.3	2,184	–0.3	2,148	–0.3
Rural SCHs	366	7.8	377	8.0	368	8.1
Rural ≤100 beds	388	3.2	371	3.3	351	4.4
Other rural	141	–0.3	137	–0.4	131	–0.4
Major teaching	269	–0.3	257	–0.3	257	–0.4
Other teaching	719	–0.1	723	0.0	707	–0.1
Nonteaching	2,138	1.0	2,089	1.1	2,034	1.2

Note: SCH (sole community hospital). Number of hospitals in groups in 2010 and 2011 do not sum to total because we could not classify one hospital in both years.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000. Previously, Medicare paid for hospital outpatient services on the basis of hospital costs. Recognizing that some hospitals might receive lower payments under the outpatient PPS than under the earlier system, the Congress established transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS.
- Transitional corridor payments expired for most hospitals at the end of 2003. However, some rural hospitals continued to receive a special category of transitional corridor payments called “hold harmless” (HH) through 2012. Qualifying hospitals receive the greater of the payments they would have received from the previous system or the actual outpatient PPS payments.
- Hospitals that qualified for HH payments in 2004 and 2005 included rural SCHs and other small rural hospitals (100 or fewer beds). After 2005, small rural hospitals continued to be eligible for HH payments, but SCHs no longer qualified. In 2006, CMS implemented a policy (the “SCH transfer”) that increased outpatient payments to rural SCHs by 7.1 percent above the standard rates. This policy is made budget neutral by reducing payments to all other hospitals. Finally, the Congress reestablished HH payments for SCHs that had 100 or fewer beds in 2009 and extended HH payments to all SCHs in 2010 and 2011. HH payments for SCHs that had more than 100 beds expired on March 1, 2012, and expired for SCHs and rural hospitals that had 100 or fewer beds on January 1, 2013.
- HH payments and the SCH transfer represented 0.4 percent of total outpatient PPS payments for all hospitals in 2010. However, the percentage of total outpatient payments from these policies was 7.8 percent for rural SCHs and 3.2 percent for small rural hospitals. Data from 2011 and 2012 indicate transfer and HH payments to rural SCHs were 8.0 percent of their outpatient revenue in 2011 and 8.1 percent in 2012. Small rural hospitals continued to benefit from HH payments in 2011 and 2012. These payments were 3.3 percent of their total outpatient payments in 2011 and 4.4 percent in 2012.

Chart 7-16. Number of observation hours has increased, 2006–2012



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system 2006–2012.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency room or clinic visits that occurred with observation care.
- The number of observation hours (both packaged and separately paid) has increased substantially, from about 23 million in 2006 to 50 million in 2012. Before 2006, it was difficult to count the total number of observation hours because hospitals were not required to report packaged observation hours on Medicare claims.

Chart 7-17. Number of Medicare-certified ASCs increased by 19 percent, 2006–2013

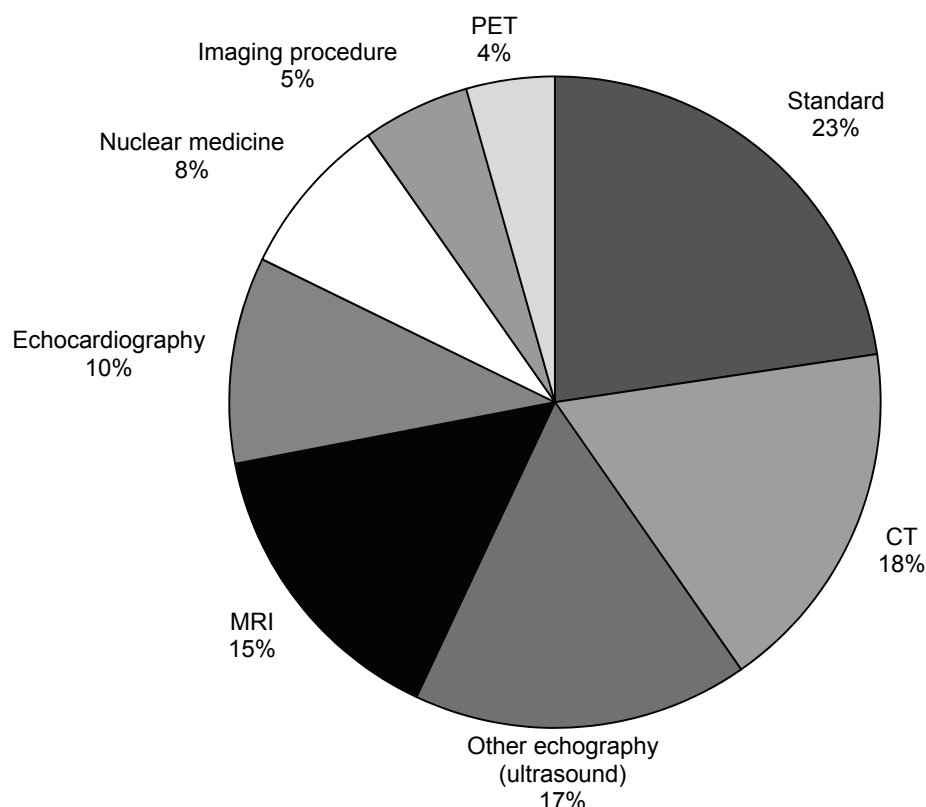
	2006	2007	2008	2009	2010	2011	2012	2013
Medicare payments (billions of dollars)	\$2.8	\$2.9	\$3.1	\$3.2	\$3.3	\$3.4	\$3.6	\$3.7
Number of centers	4,490	4,756	4,955	5,064	5,152	5,228	5,307	5,364
New centers	320	345	280	220	193	190	165	108
Exiting centers	92	79	81	111	105	114	86	51
Net percent growth in number of centers from previous year	4.5%	5.9%	4.2%	2.2%	1.7%	1.5%	1.5%	1.1%
Percent of all centers that are:								
For profit	96	96	96	96	97	97	97	96
Nonprofit	4	4	4	3	3	3	3	3
Urban	91	91	91	91	91	91	91	91
Rural	9	9	9	9	9	9	9	9

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2013 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS 2013. Payment data are from CMS, Office of the Actuary.

- ASCs are entities that furnish only outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- Total Medicare payments for ASC services increased by 3.8 percent per year, on average, from 2006 through 2013. Payments per fee-for-service beneficiary also grew by 3.8 percent per year during this period. Between 2012 and 2013, total payments rose by 1.4 percent and payments per beneficiary grew by 0.4 percent.
- The number of Medicare-certified ASCs grew at an average annual rate of 2.6 percent from 2006 through 2013. Each year from 2006 through 2013, an average of 228 new facilities entered the market, while an average of 90 closed or merged with other facilities.
- The slower growth in the number of ASCs in 2010 through 2013 may reflect the substantially higher rates that Medicare pays for ambulatory surgical services in hospital outpatient departments than in ASCs, the general slowdown in health care spending, the significant growth in hospital employment of physicians, and the major revision of the ASC payment system in 2008.

Chart 7-18. Medicare spending for imaging services under the fee schedule for physicians and other health professionals, by type of service, 2012

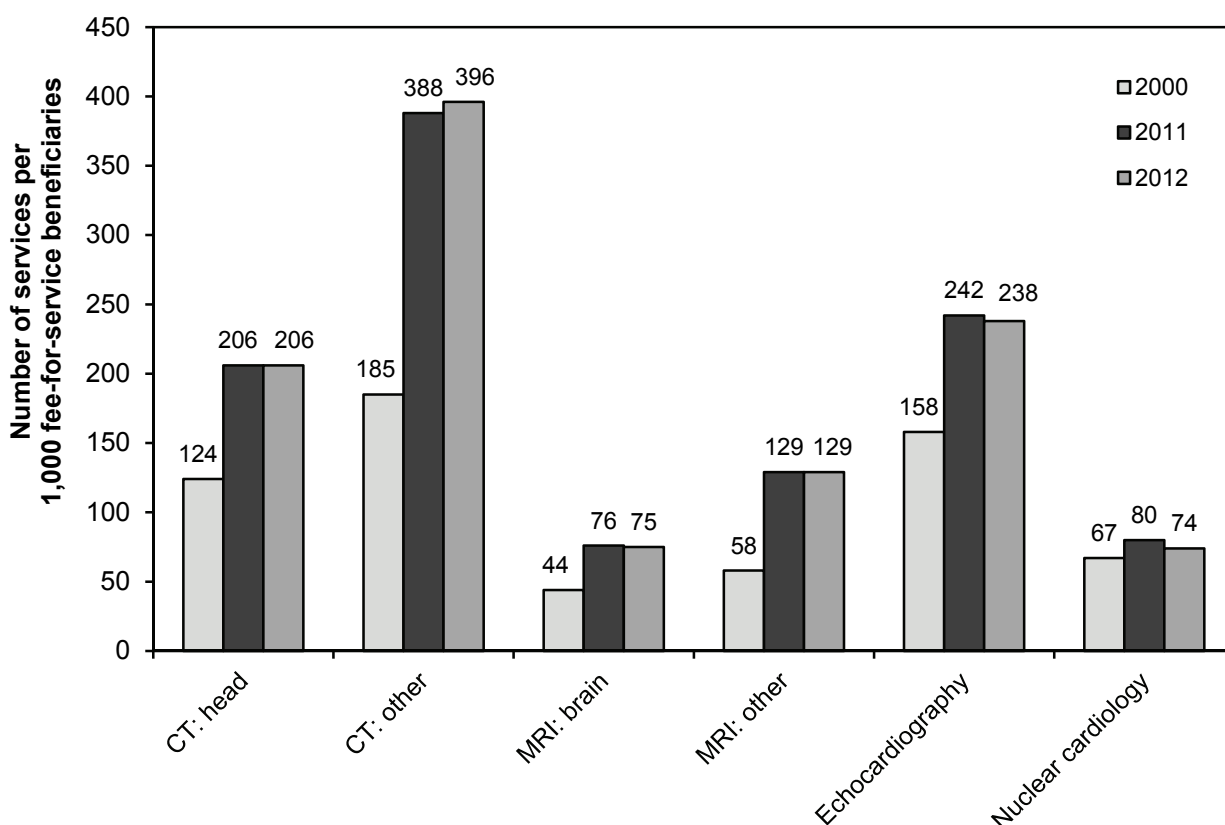


Note: PET (positron emission tomography), CT (computed tomography), MRI (magnetic resonance imaging). Standard imaging includes chest, musculoskeletal, and breast X-rays. Imaging procedures include stereoscopic X-ray guidance for delivery of radiation therapy, fluoroguide for spinal injection, and other interventional radiology procedures. Medicare payments include program spending and beneficiary cost sharing for physician fee-schedule imaging services provided in all settings. Payments include carrier-priced codes but exclude radiopharmaceuticals.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS 2012.

- One-third of Medicare spending for imaging under the physician fee schedule in 2012 was for CT and MRI studies. About one-quarter was for various types of ultrasound (echocardiography and other echography).
- Medicare and beneficiaries spent a total of \$10.0 billion for imaging services under the physician fee schedule in 2012. Spending declined from \$10.6 billion in 2011 (–5.1 percent). The decline in spending was largely due to a 3.2 percent drop in the number and complexity of imaging services per beneficiary in 2012, CMS's adoption of more current practice expense data from a new survey of practitioners, and CMS's implementation of a multiple procedure payment reduction for the professional component of advanced imaging services.

Chart 7-19. Growth in the number of CT, MRI, and cardiac imaging services per 1,000 beneficiaries, 2000–2012



Note: CT (computed tomography), MRI (magnetic resonance imaging). Data include physician fee schedule imaging services provided in all settings but exclude technical component-only services. The number of echocardiography and nuclear cardiology services exclude add-on services. The number of services classified in 2011 as “CT: other” was adjusted to account for comprehensive (bundled) codes for CT angiography that were instituted in 2012. The number of services classified in 2000 as “CT: other” was adjusted to account for comprehensive codes for CT of the abdomen and pelvis that were instituted in 2011.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary files from CMS, 2000, 2011, and 2012.

- The number of CT and MRI scans per 1,000 fee-for-service beneficiaries grew rapidly from 2000 to 2011. There was minimal change from 2011 to 2012.
- For example, the number of CT scans of parts of the body other than the head more than doubled from 2000 to 2012 (from 185 per 1,000 beneficiaries to 396).
- The number of echocardiography and nuclear cardiology studies also increased from 2000 to 2011, although not as rapidly as CT and MRI scans.
- Echocardiography services per 1,000 beneficiaries grew by 54 percent from 2000 to 2011 and declined by 2 percent in 2012. Nuclear cardiology studies increased by 19 percent from 2000 to 2011 and fell by 7 percent in 2012.

